shall proceed to liquidate or merge with another credit union. *[A. F&I]*

**AB 1533 (Tucker)**. Existing law limits check cashers' charges for cashing a payroll check with identification to 3% and without identification to 3.5%, or $3, whichever is greater. As introduced March 4, this bill would reduce these maximum charges to 1% for cashing a payroll check with identification and 1.5% for cashing a payroll check without identification, or $3, whichever is greater. *[A. F&I]*

**AB 2306 (Margolin)**, as amended May 19, would add to the acts that constitute grounds for health care service plan (HCSP) disciplinary action the failure of a plan to correct prescribed deficiencies identified by the Commissioner. *[S. InsCl&Corps]*

**AB 2002 (Woodruff)**, as amended June 28, would be known as the "Filante Health Care Act," authorizing HCSPs, nonprofit hospital service plans, and disability insurers to provide rate incentives for covered individuals or enrollees, as the case may be, to adopt healthful lifestyles, as prescribed, the rate incentives to be based on actuarial considerations related to the differences in lifestyle. The bill would require the Commissioner of Corporations to adopt guidelines by June 30, 1994, and would permit the Commissioner to adopt regulations defining a "healthful lifestyle" for HCSPs. It would also require the Insurance Commissioner to adopt guidelines and would permit the Commissioner to adopt regulations defining a "healthful lifestyle" for disability insurers and nonprofit hospital service plans. The bill would also authorize HCSPs and nonprofit hospital service plans that are certified as meeting those guidelines to indicate that they are certified plans. *[S. InsCl&Corps]*

**SB 719 (Craven)**. Existing law provides that no HCSP, including a specialized HCSP, shall request reimbursement for overpayment or reduce the level of payment to a provider based solely on the allegation that the provider has entered into a contract with any other licensed HCSP for participation in a benefit plan that has been approved by the Commissioner. As amended May 17, this bill would provide instead that no specialized HCSP that provides or arranges for dental services shall request reimbursement for overpayment or reduce the level of payment to a provider based on the that the provider has entered into a contract with any other HCSP for participation in a supplemental dental benefit plan that has been approved by the Commissioner. *[S. InsCl &Corps]*

**SB 1118 (Rogers)** would exempt any offer of a security for which an offering statement under Regulation A of the Securities Act of 1933 has been filed but has not yet been qualified. *[S. BC&IT]*

**SB 666 (Beverly)**. Existing law permits certain securities to be qualified by permit if the application is a small company application and meets certain requirements (*see above*). As introduced March 3, this bill would revise those requirements by specifically requiring the Commissioner to adopt rules containing specified requirements. Among other things, the bill would set the minimum stock price at $2 instead of $5, and incorporate by reference Form U-7 of the North American Securities Administrators Association, and associated instructions. *[S. BC&IT]*

## LITIGATION

On September 30, the California Supreme Court granted review of the Second District Court of Appeal's decision in ***People v. Charles H. Keating***, 16 Cal. App. 4th 280 (1993). In its ruling, the Second District affirmed a jury verdict in which the former savings and loan boss was found guilty of defrauding 25,000 investors out of $268 million by persuading them to buy worthless junk bonds instead of government-insured certificates. *[12:2&3 CRLR 169]*

Keating primarily challenges the trial court's jury instructions stating that Keating could be convicted under theories that he was either the direct seller of false securities in violation of Corporations Code sections 25401 and 25540, or a principal who aided and abetted the violations. Keating was convicted on 17 counts, all violations of sections 25401 and 25540. The major issue raised by Keating is whether aiding and abetting of a section 25401 crime statutorily exists; Keating claims that criminal liability is restricted to direct offerors and sellers, and that the evidence failed to prove he personally interacted with any of the investors. The Supreme Court unanimously voted to hear Keating's appeal of his state conviction, for which he received a ten-year prison term and a $250,000 fine. However, even if his state conviction is set aside by the court, Keating must serve a twelve-year term in federal prison based on his January conviction by a federal jury for racketeering, conspiracy, and fraud. *[13:4 CRLR 110]*

# DEPARTMENT OF INSURANCE

*Commissioner: John Garamendi*
*(415) 904-5410*
*Toll-Free Complaint Number:*
*1-800-927-4357*

Insurance is the only interstate business wholly regulated by the several states, rather than by the federal government. In California, this responsibility rests with the Department of Insurance (DOI), organized in 1868 and headed by the Insurance Commissioner. Insurance Code sections 12919 through 12931 set forth the Commissioner's powers and duties. Authorization for DOI is found in section 12906 of the 800-page Insurance Code; the Department's regulations are codified in Chapter 5, Title 10 of the California Code of Regulations (CCR).

The Department's designated purpose is to regulate the insurance industry in order to protect policyholders. Such regulation includes the licensing of agents and brokers, and the admission of insurers to sell in the state.

In California, the Insurance Commissioner licenses approximately 1,300 insurance companies which carry premiums of approximately $63 billion annually. Of these, 600 specialize in writing life and/or accident and health policies.

In addition to its licensing function, DOI is the principal agency involved in the collection of annual taxes paid by the insurance industry. The Department also collects more than 170 different fees levied against insurance producers and companies.

The Department also performs the following functions:

(1) regulates insurance companies for solvency by tri-annually auditing all domestic insurance companies and by selectively participating in the auditing of other companies licensed in California but organized in another state or foreign country;

(2) grants or denies security permits and other types of formal authorizations to applying insurance and title companies;

(3) reviews formally and approves or disapproves tens of thousands of insurance policies and related forms annually as required by statute, principally related to accident and health, workers' compensation, and group life insurance;

(4) establishes rates and rules for workers' compensation insurance;

(5) preapproves rates in certain lines of insurance under Proposition 103, and regulates compliance with the general rating law in others; and

(6) becomes the receiver of an insurance company in financial or other significant difficulties.

The Insurance Code empowers the Commissioner to hold hearings to determine whether brokers or carriers are complying with state law, and to order an insurer to stop doing business within the state. However, the Commissioner may not force an insurer to pay a claim—that power is reserved to the courts.

DOI has over 800 employees and is headquartered in San Francisco. Branch offices are located in San Diego, Sacramento, and Los Angeles. The Commissioner directs 21 functional divisions and bureaus.

The Underwriting Services Bureau (USB) is part of the Consumer Services Division, and handles daily consumer inquiries through the Department's toll-free complaint number. It receives more than 2,000 telephone calls each day. Almost 50% of the calls result in the mailing of a complaint form to the consumer. Depending on the nature of the returned complaint, it is then referred to Claims Services, Rating Services, Investigations, or other sections of the Division.

Since 1979, the Department has maintained the Bureau of Fraudulent Claims, charged with investigation of suspected fraud by claimants. The California insurance industry asserts that it loses more than $100 million annually to such claims. Licensees currently pay an annual assessment of $1,000 to fund the Bureau's activities.

## MAJOR PROJECTS

**DOI Releases Annual Consumer Complaint Study**. On October 25, DOI released its 1992 Consumer Complaint Study, which reveals "complaint ratios" of insurance companies which sell personal automobile, homeowner, and individual life insurance policies in California. A "complaint ratio" compares the number of justified complaints filed against a company to its policy count. Companies are ranked from the highest (worst) complaint ratio to lowest (best) complaint ratio. Insurance Code section 12921.1 requires DOI to publish the complaint ratios of insurance companies annually, to assist insurance consumers in shopping for and selecting insurance companies. *[12:4 CRLR 147; 11:4 CRLR 132]*

For purposes of the survey, a "justified complaint" is defined as a complaint in which (1) a violation of the Insurance Code, insurance contract, Department ruling and/or bulletin is uncovered; and/or (2) the insurer did not provide a substantive response to previous consumer inquiries, prompting the consumer to contact DOI to obtain a response (regardless of whether the response is favorable or unfavorable from the consumer's point of view); and/or (3) the company's actions were not consistent with its own procedures, guidelines, and/or rules, accepted industry standards, and/or practices. For purposes of its 1992 study, DOI counted all complaints closed in 1992 (regardless of when they were filed). According to the study, DOI closed 4,118 complaints against auto insurers, 1,002 complaints against homeowner insurers, and 975 complaints against life insurers in 1992. The Department says its investigations of potential violations in 1992 resulted in the recovery of $67.8 million for policyholders.

In the auto insurance area, Sterling Casualty Insurance had the worst complaint ratio. Rounding out the top ten worst auto insurance companies were Western United Insurance, Coast National Insurance, Stonewall Insurance, Colonial Penn Insurance, Calfarm Insurance, Financial Indemnity Company, Continental Insurance, Civil Service Employees, and Clarendon National Insurance. The top ten companies with the best complaint ratios include United Services Auto Association (USAA), State Farm Mutual Automobile, Allstate Indemnity, American Economy Insurance, California Casualty Indemnity, California Casualty and Fire, Liberty Mutual Fire Insurance, Wawanesa Mutual Insurance, USAA Casualty, and AMCO Insurance.

For homeowners insurance, the top ten worst companies were Farmers Insurance Exchange, Colonial Penn Insurance, Republic Insurance, Continental Insurance, Vanguard Insurance, Farmers Home Mutual, Home Indemnity, Reliance Insurance, American Bankers Insurance of Florida, and Fireman's Fund Insurance. The ten companies with the best complaint ratios include USAA Insurance Company, Allstate Indemnity, USAA Casualty, State Farm General Insurance, American Economy Insurance, American National Fire, Liberty Mutual Fire Insurance, State Farm Fire and Casualty, Government Employees Insurance Company (GEICO), and American Manufacturers Mutual Insurance.

In the life insurance area, the top ten worst companies were Crown Life, Provident Mutual Life of Philadelphia, Security Life of Denver, Jackson National Life, Connecticut General Life, ITT Life, IDS Life, Pacific Mutual Life, Primerica Life Insurance, and General American Life. The top ten best companies were Farmers New World Life, AID Association for Lutherans, State Farm Life, North American Life and Health, Principal Mutual Life, Northwestern Mutual Life, Federal Kemper Life Assurance, USAA Life, Independent Order of Foresters, and New England Mutual Life.

DOI's 1992 study did not include ratings for health and disability companies. In 1992, Blue Cross became a health care service plan under the jurisdiction of the Department of Corporations, thus reducing DOI's authority over health care providers in California to less than 30%. Since DOI is provided with complaint information on a very small segment of the health care market, it decided not to include the health and disability line of insurance in the 1992 survey.

**DOI Holds Investigative Hearings on Telephone Quote Accuracy and Availability**. On October 19 in Los Angeles and October 20 in San Francisco, DOI conducted public investigative hearings on the high percentage of inaccurate quotes it received in its 1992–93 anonymous telephone survey to obtain quotes for private passenger automobile coverage. After its survey, DOI published a report entitled *Study of Telephone Quote Accuracy and Availability: The Private Passenger Automobile Insurance Maze*, which identified the companies which provided inaccurate phone quotes, engaged in discriminatory practices, and—in general—made it difficult for California consumers to purchase insurance. Of 396 quotes received by DOI from agents or sales representatives of 24 insurance companies, only 71 matched the official company quotes. The companies which were most inaccurate are Farmers, Hartford, and Fireman's Fund, all with zero correct quotes. The companies which were most accurate include CSAA (40% of its quotes were accurate), Allstate (25% were accurate), and State Farm (20% were accurate). *[13:4 CRLR 112–13]*

At the hearings, the Department received testimony from agents and various insurance company representatives, as well as testimony from consumer organizations, as to why quoted rates are inaccurate. DOI also subpoenaed documents from various insurance companies, and is currently reviewing them. At this writing, DOI is expected to issue a report and recommendations on the hearings in early 1994.

**Rulemaking Proceeding and Public Investigative Hearing to Develop Proposition 103 Auto Rating Factors and Good Driver Discount Regulations**. On November 18, the Office of Administrative Law (OAL) reapproved (for the tenth time) DOI's emergency adoption of sections 2632.1–2632.18, Title 10 of the

CCR. These interim emergency regulations define relevant statutory terms used in both the auto rating factor and good driver discount provisions of Proposition 103, set forth the additional factors (*i.e.*, factors other than the three stated in Proposition 103) which may be used by insurers to determine auto insurance rates, specify the weight which may be assigned to those additional factors in determining rates, and set guidelines for determining a driver's status as a good driver. *[13:4 CRLR 111–12]*

The interim regulations have been in effect since August 1990, and will remain in effect until the Commissioner completes an ongoing rulemaking proceeding to develop new ones. On September 17, the Commissioner held an initial public hearing on his proposal to adopt permanent regulations (sections 2632.1–2632.16, Title 10 of the CCR) which are somewhat similar to the interim regulations, but which contain four alternatives for determining the weight which may and should be accorded to rating factors in setting rates and premiums. The alternatives (which are set forth in proposed section 2632.6) vary from general requirements which leave the methodology to an insurer's discretion, to methodologies which define "variance" and specify the manner in which variance must be modified, if necessary.

Simultaneously, the Commissioner announced that DOI will hold a public investigative hearing concerning the four alternative methodologies for determining weights of rating factors set forth in proposed section 2632.6. According to the announcement, "the investigative hearing will be in the nature of a symposium of persons having technical expertise in insurance ratemaking, statistics, and actuarial matters." The Commissioner structured the investigative hearing to occur in two phases: (1) In Phase I, interested persons were required to submit written materials and comments on the weighting methodologies to the Commissioner by October 1; and (2) Phase II will consist of a public hearing at which time comments submitted during Phase I will be discussed by the participants. At this writing, the Commissioner has scheduled the Phase II hearing for January 27.

**OAL Rejects Anti-Redlining Regulation**. In a 70-page opinion dated November 8, OAL rejected the Department's proposed adoption of section 2646.6, Title 10 of the CCR, which seeks to establish standards designed to curb the widespread industry practice of "redlining"—the refusal or failure to sell insurance to low-income and minority communities. To achieve this purpose, section 2646.6 would require insurers to annually provide specified information to the Commissioner; allow the Commissioner to use that information in considering rate change applications; require the Commissioner to annually identify communities which are "underserved by the insurance industry" and report on services provided by insurers to underserved communities; require the Commissioner to rank insurers by willingness and ability to serve underserved communities; require lower-ranked insurers to develop marketing plans targeting underserved communities; require insurers which decline to provide coverage in an underserved area to provide a statement of reasons to applicants; and require insurers to maintain and advertise a statewide toll-free telephone number. *[13:1 CRLR 83–84; 12:4 CRLR 145–46]*

Among other things, OAL found that the Commissioner failed to satisfy his burden of demonstrating that he is authorized to adopt the proposed regulation. During the comment period, many insurance companies filed extensive legal briefs challenging the authority of the Commissioner to address the redlining issue. In its rulemaking record, DOI rebutted the insurers' contentions by citing to numerous statutes (including Insurance Code sections 679.71, 11628, 1861.02, 1861.03, and 1861.05) which prohibit "discrimination" in the offer or sale of specified insurance policies; based on these provisions, the Commissioner concluded that he is authorized to adopt the regulation and summarily rejected the comments of the industry. OAL found that although the cited statutes provide some authority for some parts of the challenged rule, the Commissioner failed to cite to any statute which "expressly or implicitly establish[es] obligations regarding service to underserved communities" or authorizes him to implement such as provision. OAL acknowledged that "[l]egislative action can of course change the scope of the statutes at issue in the instant action," noting that SB 1106 (Torres) is currently pending in the legislature "with provisions that are remarkably similar in many respects to the provisions of rule 2646.6" (*see* LEGISLATION).

On the authority issue, OAL sided with the insurance industry, and even inserted into its rejection decision a six-page single-spaced quote from the brief of one company addressing the definition of the term "unfairly discriminatory." The industry asserts that existing statutes cited by the Commissioner prohibiting "discrimination" (and impliedly authorizing the Commissioner to address "discrimination") deal "not with racial or ethnic discrimination but with price discrimination....What is prohibited by the term 'unfairly discriminatory' is discrimination between groups of insureds with like loss experience...." OAL found that the Commissioner's disagreement with and summary rejection of this position "does not constitute an explanation of the reasons for rejecting the comment as required by Government Code section 11346.7(b)(3)."

OAL also found that the Commissioner's rulemaking file failed to comply with the consistency standard of Government Code section 11349.1(a). For example, one provision of section 2646.6 would require insurers to collect information on the race or national origin of each applicant for insurance "on the application form or on a separate form that refers to the application." OAL found this provision to be inconsistent with Insurance Code section 679.72, which states that "[n]o application for insurance...furnished by...an insurer to its agents or employees for use in determining the insurability of the applicant shall carry any identification, or any requirement therefor, of the applicant's race, color, religion, national origin, or ancestry."

OAL also rejected section 2646.6 for its lack of clarity in numerous areas, and for its failure to satisfy the necessity standard of Government Code section 11349.1(a). Finally, OAL found that the Department failed to fully comply with the rulemaking requirements of the Administrative Procedure Act in that it failed to respond to or explain its rejection of all comments received; failed to properly incorporate by reference any or all of its Insurance Statistical Plan into the regulation; improperly included non-regulatory findings and a "purpose statement" in the text of the regulation rather than in the initial statement of reasons; and failed to include a finding that the reporting required under the proposed section is "necessary for the health, safety or welfare of the people of the state" as required by Government Code section 11346.53(f).

DOI has 120 days from the date of OAL's rejection in which to cure the deficiencies cited and resubmit the rulemaking record to OAL.

**DOI Ratesetting to Establish Maximum Prima Facie Rates for Credit Life and Credit Disability Insurance**. Credit life insurance is designed to pay off a debtor's indebtedness should he or she die. Credit disability insurance is designed to pay the installments on a debtor's indebtedness as they become due while he or she is disabled. In the 1950s, a number of specialized "credit insurance" products evolved to serve this market. Credit insur-

ance on short-term (five or ten years) "small" loans (*e.g.* for an automobile, furniture, appliances, and other large consumer goods) is frequently sold along with the item at point of sale by consumer goods sellers or lenders. The Department contends that because sellers make large commissions on the sale of credit insurance and the policies pay out very little in benefits in relation to premiums paid, the profits to sellers and insurers are considerable, and unsophisticated consumers are frequently victimized by seller coercion and overreaching.

These abuses led to 1959 legislation authorizing the Insurance Commissioner to disapprove premium rates for credit insurance if the benefits paid were "unreasonable" in relation to the premium charged. However, DOI regulation of credit insurance rates was abruptly halted in 1985 with the enactment of Insurance Code section 779.35 (Chapter 1316, Statutes of 1985)—a bill which former Senator Alan Robbins later admitted taking a $12,000 bribe to help enact. That law froze credit life and disability insurance rates at those provided in DOI regulations in effect on March 5, 1985, and stripped the Insurance Commissioner of the authority to regulate rates for credit insurance. Consumers Union maintains that, following enactment of the Robbins-supported bill, insurers earned over $600 million per year in California on excessive premiums for credit insurance. *[11:3 CRLR 33; 10:4 CRLR 27–28]*

After a major lobbying campaign by consumer groups (assisted by Robbins' December 1991 guilty plea on federal charges of bribery, racketeering, and extortion), AB 2107 (Connelly) (Chapter 32, Statutes of 1992) was finally enacted. *[12:2&3 CRLR 178]* Under AB 2107, the Insurance Commissioner regained the authority to regulate rates for credit life and credit disability insurance policies. AB 2107 repealed the 1985 Robbins law and added section 779.36 to the Insurance Code, which requires the Commissioner to adopt regulations to become effective no later than January 1, 1994, "specifying prima facie premium rates based on presumptive loss ratios, not to exceed 60%, for each class of credit disability and credit life insurance subject to this article." In order to ensure that insurers have an opportunity to earn a fair rate of return, AB 2107 requires the Commissioner, in establishing maximum rates, to consider "acquisition costs, including commissions and other forms of compensation, expenses, profits, loss ratios, reserves, and other actuarial considerations."

Thus, on October 27 and 28, DOI held public hearings on its proposal to amend sections 2248–2248.20, Article 6.7, Title 10 of the CCR, and adopt new Article 6.8 (sections 2248.30–.47), Title 10 of the CCR, to implement AB 2107 and establish maximum prima facie credit life and credit disability rates. Since this rulemaking pertains only to the fixing of rates, DOI noted that it is exempt from the timeframe requirements of the Administrative Procedure Act under Government Code section 11343(a)(1).

In the area of credit life insurance, the annual premium rates in existing regulations would be replaced by rates expressed on a monthly basis, setting forth maximum prima facie life insurance rates per $1,000 of monthly outstanding loan balance at a 55% presumptive loss ratio and at a 60% presumptive loss ratio for both open end and closed end coverages. According to DOI, the proposed rates have been derived by applying the presumptive loss ratio to the last three years' experience reported to DOI, with an allowance in excess of 10% for expenses, profits, etc. DOI's existing regulations provide that single life insurance premiums are computed by multiplying the prima facie rate by the number of years of coverage and the initial insured amount and dividing the total by $100. Under the proposed regulations, single life insurance premiums are computed by calculating the premium for each month in the term by multiplying the prima facie rate by the scheduled outstanding balance of the loan for that month (divided by $1,000) and discounting the result to determine its present value. The monthly premiums are then accumulated to determine the single premium. The proposed regulations set forth a similar formula for the calculation of premiums for closed end loans, open end loans, and joint life coverages.

In the area of credit disability insurance, DOI's proposed regulations would continue to utilize the formulas for calculating premiums set forth in its existing regulations, and more clearly define the way in which the prima facie rate is to be applied to determine the premium charge for coverage of a specific loan. The proposed regulations also establish a formula for calculating joint disability coverage, which is prohibited by the existing regulations but permitted in AB 2107.

At the October 27–28 public hearings, numerous insurance industry representatives argued—among other things—that the prima facie maximum rates would deprive them of a fair rate of return and that the industry could not possibly comply with the new regulations by January 1. On November 19, the Commissioner released modified language of these regulations. The modified language includes increased maximum rates for both life and disability credit insurance, and a delayed effective date—compliance with the new regulations will not be mandatory until 180 days after their effective date. At this writing, the proposed regulatory package has not yet been approved by the Commissioner.

**Other DOI Rulemaking**. The following is a status update on other DOI rulemaking proceedings covered in detail in recent issues of the *Reporter*:

• ***Licensing of Insurance Claims Analysis Bureaus***. Following public hearings on August 11 and 18, DOI is still reviewing the comments received on held its proposal to adopt new section 2698.30–.36, Title 10 of the CCR, to implement Insurance Code section 1871 *et seq.* regarding the licensure of insurance claims analysis bureaus (CABs) to assist the public, regulators, law enforcement, prosecutors, and insurers in suppressing and preventing insurance claims fraud. A CAB is a nonprofit corporation which receives, compiles, and disseminates insurance claims information and provides education and training, solely for the purpose of preventing and suppressing insurance fraud. These regulations specify the qualifications for CAB licensure, the conditions under which the insurance claims information will be disseminated by the CABs, the provisions for anti-fraud education and training of CAB members or subscribers, and the penalties to be assessed against licensed CABs for noncompliance with these regulations. *[13:4 CRLR 113]*

• ***Rulemaking to Establish Special Investigative Units***. On August 12 and 25, DOI held public hearings on its proposal to adopt sections 2698.40–.45, Title 10 of the CCR; these regulations will define the duties, function, and role of the special investigative units (SIUs) which each admitted insurer is required to maintain. SIUs investigate suspected fraudulent claims by insureds or by persons making claims for services or repairs against policies held by insureds. Among other things, SIUs are required to cooperate with DOI's Fraud Division and other law enforcement agencies and authorized governmental agencies to assure compliance with the Insurance Code, and to provide a prompt response to requests made in the course of any criminal or civil investigation. *[13:4 CRLR 113]* Following the hearings, DOI released modified language of the regulatory proposal for a 15-day comment period; among other things, the modifications revise the definition of "investigation" and exempt reinsurers and home warranty protection insurance from the rule. At this writing, DOI is expected

to submit the rulemaking file on the proposed regulations to OAL in the near future.

• ***Rulemaking to Implement AB 1672 (Margolin).*** On October 28, DOI readopted emergency regulations to implement AB 1672 (Margolin) (Chapter 1128, Statutes of 1992), which became effective on July 1, 1993. AB 1672, which added sections 10198.6–.9 and 10700–10749 to the Insurance Code, dramatically restructured California's market for health insurance for employees of "small employers." *[13:4 CRLR 113–14; 13:2&3 CRLR 132–33]* Emergency sections 2233–2233.99 (nonconsecutive), Title 10 of the CCR, define key terms in the statute, clarify existing ambiguities in the law, and attempt to bring as many sources of health coverage as possible within the jurisdiction of AB 1672. The October emergency regulations also reflect changes to AB 1672's small employer provisions (Insurance Code sections 10700–10718.6) made by bills enacted during 1993, including AB 1742 (Margolin) (Chapter 113, Statutes of 1993), AB 28 (Margolin) (Chapter 1146, Statutes of 1993), and AB 2059 (Margolin) (Chapter 217, Statutes of 1993). The emergency regulations are effective for another 120-day period.

• Life Insurance Disclosure Regulations. On December 10, DOI released a second modified version of its proposal to repeal sections 2545–2545.5 and adopt new sections 2546–2546.8, Title 10 of the CCR, which would require sellers of life insurance to adhere to new disclosure requirements to enable consumers to more readily compare the costs and benefits of life insurance policies. *[13:4 CRLR 114; 13:2&3 CRLR 131]* The comment period on the second modified version closed on December 30; at this writing, DOI is reviewing the comments received.

• ***Rate Hearing Timelines and Procedures.*** On December 17, OAL approved DOI's permanent adoption of new sections 2648.1, 2648.2, 2648.3, and 2648.4, Title 10 of the CCR, which establish timelines for scheduling and commencing administrative hearings on insurers' applications for rate changes pursuant to Insurance Code section 1861.05(c) filed with the Department after July 1, 1993. Rate change applications filed under section 1861.05(c) are deemed approved by the Commissioner unless they are rejected after a DOI administrative hearing within 180 days of the Commissioner's receipt of the application, or unless extraordinary circumstances exist. *[13:4 CRLR 114–15; 13:2&3 CRLR 131]*

• ***CAARP Coverage for Good Drivers.*** DOI staff is still reviewing comments received on the Department's proposed adoption of section 2632.14.3, Title 10 of the CCR. This rulemaking action will implement AB 2605 (Peace) (Chapter 1255, Statutes of 1992), which provides that an insurer which refuses to issue a good driver discount policy to an eligible good driver must state its refusal in writing and provide the applicant with a certificate of eligibility authorizing the applicant to obtain private passenger automobile liability coverage through the California Automobile Assigned Risk Program (CAARP). *[13:2&3 CRLR 131–32]* At this writing, section 2632.14.3 has not yet been submitted to OAL for approval.

• ***"Substantial Increase in the Hazard Insured Against."*** On December 2, OAL approved DOI's adoption of section 2632.19, which defines the term "substantial increase in the hazard insured against"—one of the three acceptable grounds for cancellation or nonrenewal of an automobile insurance policy established by Proposition 103. *[13:4 CRLR 115; 13:2&3 CRLR 132; 13:1 CRLR 83]*

• ***Insurance Fraud Prevention Funding.*** On October 8, OAL approved DOI's adoption of new sections 2698.6–2698.67 (formerly numbered as sections 2692.1–2692.8) and 2698.5–2698.59 (formerly numbered as sections 2693.1–2693.10), Title 10 of the CCR, which establish a mechanism for the distribution of funds to district attorney's offices for the investigation and prosecution of automobile insurance fraud and workers' compensation fraud, respectively. *[13:4 CRLR 115; 13:2&3 CRLR 132; 12:2&3 CRLR 172]*

**Investigatory Hearings on Availability and Affordability of Non-Auto Lines of Insurance.** On October 14 in Los Angeles, October 27 in Oakland, and November 4 in Fresno, DOI held a series of public investigatory hearings on the availability and affordability of non-automobile lines of insurance. At these hearings, a special investigatory panel of top DOI staff heard oral testimony and received written testimony from consumers and insurers regarding their particular concerns and difficulties in purchasing and selling midwifery malpractice insurance, commercial liability insurance, contractors' insurance, homeowners insurance, and surety insurance. At this writing, the Department is expected to issue a report on its findings in February 1994.

Additionally, the Commissioner held separate hearings on the availability and affordability environmental insurance and insurance for child care facilities. DOI plans to publish a separate report on these lines.

**Intervenor Compensation Rates.** Throughout 1992, DOI spent a good deal of time and effort on a rulemaking proceeding implementing a provision of Proposition 103 which requires the Commissioner to establish an "intervenor compensation" program whereby attorneys and experts who represent consumer interests in certain DOI proceedings may recover "reasonable" advocacy fees and expenses if they make a substantial contribution to the Commissioner's adoption of any order, regulation, or decision. In order to encourage active and competent consumer representation, the regulations which resulted from that proceeding promised to pay "market rates" to attorneys and experts who intervene on behalf of consumer interests, defined as "the average billing rates of comparable attorneys, advocates or experts in Los Angeles and the San Francisco Bay Area." *[13:2&3 CRLR 132; 12:2&3 CRLR 171; 12:1 CRLR 119]*

Following OAL's approval of the intervenor compensation rules, DOI implemented the "market rates" provision by placing a cap on intervenor compensation fees at $195 per hour. Last year, the cap was challenged by attorneys from San Francisco-based Public Advocates (PA), which sought compensation for some of its most experienced attorneys at rates exceeding the cap (*e.g.*, $315 per hour for its senior staff attorney who has twenty years of public interest litigation experience); PA also challenged DOI's disallowance of some hours worked on a lengthy administrative hearing. Last June in *Minority/Low-Income/Consumer Coalition v. Garamendi*, No. 942151 (San Francisco Superior Court), Judge Stuart Pollak ordered the Commission to abandon the cap, pay "prevailing market rates," and compensate for all hours billed by PA for the administrative hearing.

To implement Judge Pollak's ruling, during August and September 1993 DOI conducted a study of hourly fees paid in northern and southern California to attorneys who represent consumers at regulatory hearings; the Department's goal was to ascertain the prevailing hourly market rates in both regions. However, the study proved inconclusive, because the data collected indicated a wide disparity between hourly attorney fees payable to counsel of comparable experience who had appeared in regulatory or administrative matters before DOI or other state regulatory agencies.

Thus, on September 15 and again on October 7, DOI published notices seeking written comments concerning the determination of (1) what is a fair market rate; and (2) what would be considered "reasonable" for the payment of awards to

attorneys and advocates who represent consumers at DOI's regulatory hearings. Among other things, DOI sought comments on current standards and guidelines used by insurers, attorneys who represent insurers, and attorneys who represent consumers in determining an hourly rate for legal representation in regulatory or administrative hearings; the factors which should be utilized in determining a reasonable market rate that is fair compensation for attorneys who appear on behalf of consumers in DOI regulatory matters; whether the criteria in establishing a reasonable and fair market rate for intervenor awards should consider fees paid to public interest attorneys per hour, as well as hourly fees payable to insurance counsel in the private sector; and the minimum level of experience, relevant to comparable payment of minimum and maximum compensation for intervenor awards.

Written comments were due by November 1. At this writing, DOI Public Advisor Fred Butler is reviewing the comments received.

## LEGISLATION

**AB 135 (Peace).** Existing law provides that it is unlawful to make a false automobile insurance claim. As amended June 28, this bill would enact the Automobile Insurance Truth in Advertising Act to provide that any advertisement, as specified, which solicits persons to present or file automobile insurance claims or to engage or consult counsel to consider an automobile insurance claim, shall contain or include, as specified, a notice or statement that making a false or fraudulent automobile insurance claim is a felony punishable by up to five years in prison or by a fine of up to $50,000 or, if the fraud exceeds $50,000, double the value of the fraud, or by both imprisonment and fine; provide that any advertisement or other device designed to produce leads based on a response from a person to present or file an automobile insurance claim or to engage or consult counsel shall disclose that an agent may contact the individual if that is the fact; prohibit an advertisement, as defined, from using deceptive or misleading names or words or symbols implying that a governmental agency or charitable institution is connected with the advertisement; and provide that any advertiser, as defined, who violates these provisions is guilty of a misdemeanor. *[A. F&I]*

**SB 957 (Johnston).** Existing law, added by Proposition 103, provides that the rate charged for a good driver discount policy shall comply with specified criteria and be at least 20% below the rate an insured would otherwise be charged for the same coverage. As amended April 15, this bill would authorize insurers to file a rate for insureds who do not qualify as good drivers for an amount less than that required pursuant to existing provisions where the insurer can demonstrate actuarially credible experience that justifies a lower rate for that class of insured. *[S. InsCl&Corps]*

**AB 1512 (Brulte).** Existing law provides that the Insurance Commissioner may appoint administrative law judges with respect to proposed insurance rate change hearings. As introduced March 4, this bill would delete that authority. *[A. F&I]*

**AB 2128 (W. Brown).** Insurance Code section 790.03 prohibits certain acts or practices in the business of insurance that constitute unfair methods of competition or are unfair or deceptive. As introduced June 2, this bill would require any person engaged in the business of insurance to act in good faith toward current and prospective policyholders and other persons intended to be protected by any policy of insurance. Reversing the California Supreme Court's decision in *Moradi-Shalal v. Fireman's Fund Insurance Companies*, 46 Cal. 3d 287 (1988) *[8:4 CRLR 87]*, and reinstating the so-called "*Royal Globe*" cause of action, this bill would authorize third-party claims against an insurer or licensee for violation of specified laws and regulations prohibiting unfair competition and unfair or deceptive acts or practices. This bill would provide that the rights and remedies provided by the above-specified laws, and the rights and remedies arising out of a covenant of good faith and fair dealing, expressed or implied in any insurance contract or policy, shall constitute mandated benefits implied in every insurance contract or policy. This bill is sponsored by the California Trial Lawyers Association (CTLA). *[S. Jud]*

**AB 2035 (Isenberg),** as amended June 14, would—contingent upon the enactment of two unspecified Assembly Bills effective January 1, 1994—prohibit a cause of action alleging general damages for bodily injury resulting from an automobile collision from being filed in a justice, municipal, or superior court unless the court first determines that the injuries involved are serious, as defined; impose a duty on third-party insurers to deal fairly and in good faith with all parties to the action once such a determination is made, but not before; and provide that a breach of that duty is actionable, as specified. The bill would become operative July 1, 1994. *[A. Jud]*

**SB 684 (Torres),** as amended May 18, would require motor vehicle insurers to report specified information to the Commissioner, and require the Commissioner to make the information available to the public and local law enforcement officials. Among other things, this bill would also require each insurer to pay an annual fee of $1.10 for each vehicle under an insurance policy it issues; $0.10 of that fee would be used for the Automobile Insurance Claims Depository, $0.45 would be distributed to local law enforcement agencies for investigation and prosecution of automobile fraud cases; and $0.55 would be distributed to DOI's Bureau of Fraudulent Claims. *[S. Jud]*

**AB 456 (Johnson).** Under existing law, a person may recover damages for an injury arising out of the operation of a motor vehicle from a person who is liable in tort. Existing law generally requires every driver and owner of a motor vehicle to maintain a form of financial responsibility, which generally is a policy of liability insurance. As amended June 15, this bill would require each motor vehicle required to be registered in this state to be insured for basic personal protection, subject to various limits including an aggregate limit of $50,000 per person; require insurers to offer additional benefits; provide in any accident caused in whole or part by the negligence of a personal protection benefits insured, that person would be exempt from liability except as specified; prohibit an uninsured motorist from bringing an action for property damage except for damage that exceeds $5,000; limit health care fees, and would require health care providers to provide insurers with a sworn statement under penalty of perjury; and would require disputes to be submitted to arbitration. *[A. F&I]*

**AB 574 (Johnson).** Existing law requires an applicant for a driver's license to file an application with the Department of Motor Vehicles (DMV) and take an examination testing, among other things, the applicant's understanding of traffic signs and signals. As amended March 22, this bill would additionally require an applicant for the issuance or renewal of a driver's license to qualify for a Good Driver Discount insurance policy, as defined, or, in the alternative, to file proof of financial responsibility, as specified, with the Department. *[A. Trans]*

**AB 2033 (Caldera).** Existing law requires the Insurance Commissioner to approve or issue a reasonable plan for the equitable apportionment among liability insurers of applicants for automobile liability insurance who are otherwise unable to obtain that insurance. As amended April 15, this bill would create the California Basic Liability Coverage Premium Exchange, consisting of all insurers licensed

to write and engaged in writing within this state basic liability coverage for private passenger automobiles. The bill would require members to sell basic automobile insurance, and would provide for the redistribution of premiums among members, as specified. The bill would provide for a maximum rate until a specified date.

Existing law requires owners of motor vehicles to maintain in force one of the forms of financial responsibility specified in law. This bill would require DMV to require proof of financial responsibility upon registration of a motor vehicle. AB 2033 would become operative only if other unspecified bills are chaptered before it is chaptered; AB 2033 would remain in effect only until January 1, 1999. *[A. F&I]*

**AB 1674 (Margolin)**. Under existing law, persons insured under policies of private passenger automobile insurance have a right to be informed, upon request, of any change in premium based upon accidents or convictions and, in the event of cancellation, the right to be informed, upon written request, of the reason for cancellation. Under existing law, a notice of cancellation of certain types of property insurance is required to be in writing, and to inform the insured that, upon written request, the insured is entitled to be informed of the reason for cancellation. As introduced March 4, this bill would revise those provisions to provide that the reason for a change in premium or coverage, or the reason for cancellation, must accompany the notice of change in premium or coverage or notice of cancellation. The bill would require notice of increases in premiums for life insurance. The bill would require notices of nonrenewal of private passenger automobile insurance or certain property insurance to be in writing and to contain a statement of reasons. The bill would require notice of renewal or nonrenewal of private passenger automobile insurance to be given at least 45 days, instead of 20 days, prior to policy expiration, and would make related changes. *[S. InsCl&Corps]*

**AB 9 (Mountjoy)**, as amended May 20, would—among other things—provide that the workers' compensation law shall be liberally construed after the employee has established all conditions for compensability, including injury arising out of and occurring in the course of employment, by a preponderance of evidence; provide that the psychiatric aggravation of a physical injury or disease arising outside of the course and scope of employment is not compensable; provide that no compensation shall be paid for a psychiatric injury claim filed after the employee has been laid off or terminated unless the employee has established in a civil action otherwise authorized by law that the personnel action was illegal, discriminatory, or in bad faith; and provide that an employer has the right to examine the entire claim file of its insurer concerning any claim against the employer, except those documents which the insurer is privileged from disclosing to the employer under the attorney-client privilege. *[A. F&I]*

**AB 2034 (Polanco)**. Existing law authorizes the Administrative Director of the Division of Workers' Compensation to prepare and establish an official medical fee schedule for medical services, provided pursuant to the workers' compensation laws, for industrial accidents. Existing law does not provide for a medical fee schedule for medical costs incurred under a policy of automobile liability insurance. As amended April 19, this bill would provide that any charge for provision a covered service, as defined, by any health professional for any injury resulting from an automobile accident occurring on or after January 1, 1994, shall not exceed charges permitted under the above-specified schedules for industrial accidents, except as specified. This bill would also require the Insurance Commissioner, in consultation with the Administrative Director, to adopt rules and regulations implementing and coordinating these requirements with the workers' compensation laws regarding medical fee schedules, as specified.

This bill would prohibit a health professional from charging a fee for covered services in excess of the fee schedules adopted by the Commissioner and would require insurers to report to DOI's Bureau of Fraudulent Claims improper actions by health professionals in connection with a claim for services. This bill would also require the Commissioner to issue regulations establishing an arbitration system for resolution of fee disputes between health professionals and insurers. *[A. F&I]*

**AB 997 (Tucker)**. Existing law requires every private employer to secure the payment of workers' compensation by obtaining insurance or becoming self-insured. Where an employer fails to secure these payments, the Director of Industrial Relations is required to issue a stop order prohibiting the use of labor by the employer and to assess monetary penalties of $2,000–$10,000 per employee at the time the appeal becomes final. As amended May 12, this bill would require the uninsured employer to pay, in addition to these penalties, the approximate amount of workers' compensation insurance premiums the employer would have been liable for during the period of time the employer was uninsured. *[A. F&I]*

**AB 1770 (Margolin)**. Existing law generally requires a group policy of health insurance to provide for conversion rights to an insured whose coverage is terminated. Existing law provides that those requirements do not require an insurer to issue a converted policy covering any person if such person is entitled to be covered by Medicare. As amended August 17, this bill would instead require an insurer to offer a converted policy to any person entitled to be covered by the federal Medicare program to the extent that the converted policy does not duplicate Medicare benefits. *[S. Floor]*

**AB 2002 (Woodruff)**, as amended June 28, would be known as the "Filante Health Care Act." It would authorize health care service plans (HCSPs), nonprofit hospital service plans, and disability insurers to provide rate incentives for covered individuals or enrollees, as the case may be, to adopt healthful lifestyles, as prescribed, the rate incentives to be based on actuarial considerations related to the differences in lifestyle. The bill would require the Commissioner of Corporations to adopt guidelines by June 30, 1994, and would permit the Commissioner to adopt regulations defining a "healthful lifestyle" for HCSPs. It would also require the Insurance Commissioner to adopt guidelines and would permit the Commissioner to adopt regulations defining a "healthful lifestyle" for disability insurers and nonprofit hospital service plans. *[S. InsCl&Corps]*

**SB 1146 (Johnston)**. Existing law provides that a HCSP, a self-insured employee welfare benefit plan, a disability insurer, a life insurer, or a nonprofit hospital service plan may not refuse to enroll any person or accept any person as a subscriber or insured solely by reason of the fact that the person carries a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Existing law contains similar provisions prohibiting rate discrimination and commission discrimination on that basis. Violation of these provisions with regard to a HCSP is punishable as a crime. As introduced March 5, this bill would prohibit those forms of refusal and discrimination by HCSPs, self-insured employee welfare benefit plans, disability insurers other than disability income insurers, and nonprofit hospital service plans on the basis that the person carries a gene which may, under some circumstances, be associated with disability in that person or that person's offspring.

Existing law also provides that no life or disability insurer shall fail or refuse to accept an application or to issue insurance, or issue or cancel insurance, except with regard to reasons applicable alike to persons of every race, color, religion, national origin, ancestry, or sexual orientation, and that these reasons shall not, of themselves, constitute a risk for which a higher rate, premium, or charge may be required. This bill would additionally provide that, effective until January 1, 2002, except as otherwise permitted by law, these insurers shall not fail or refuse to accept an application or to issue insurance, cancel insurance, charge a higher rate or premium, or place a limitation on coverage, on the basis of a test of a person's genetic characteristics, as specified. However, the bill would permit a life or disability income insurer to decline an application or enrollment request, charge a higher rate or premium, or place a limitation on coverage, on the basis of a test of a person's genetic characteristics, with regard to policies issued or delivered on or after January 1, 1994, which are contingent upon review or testing for other diseases or medical conditions, subject to certain informed consent and privacy protections. *[A. Health]*

**SB 38 (Torres)**, a reintroduction of SB 6 (Torres) (which was vetoed by Governor Wilson on September 30, 1992 *[12:4 CRLR 149]*) has been amended into **SB 1098 (Torres)**. As amended September 8, SB 1098 would create the California Health Plan Commission, with specified powers and duties, which would establish and maintain a program of universal health coverage to be known as the California Health Plan. The bill would require that, under the plan, all California residents would be eligible for the same federally required package of comprehensive health care services, and all California residents would be eligible to participate without regard to employment status or place of employment in accordance with applicable federal requirements. The bill would require the Commission to establish and fund regional health insurance purchasing corporations (HIPCs), with certain duties. The bill would require, on or after January 1, 1995, the HIPCs, the Commission, or another agency designated by the Commission, to enter into contracts with health plans for the purpose of providing health benefits coverage to all eligible persons. The bill would require, on or before January 1, 1995, the Commission to adopt regulations to implement these provisions and to prepare a plan, budget, and timetable for the transfer of funds and entitlements under the Medi-Cal program, as required by federal law, to the Commission. *[S. Conference Committee]*

**SB 1106 (Torres)**. Existing law prohibits admitted insurers, excluding automobile and workers' compensation insurers, from failing or refusing to accept an application for, or issuing a policy to, an applicant for that insurance, or cancelling that insurance, under conditions less favorable to the insured than in other comparable cases, except for reasons applicable alike to persons of every marital status, sex, race, color, religion, national origin, or ancestry; nor may sex, race, color, religion, national origin, or ancestry of itself constitute a condition or risk for which a higher rate, premium, or charge may be required of the insured for that insurance. As amended August 24, this bill would enact a comprehensive anti-redlining scheme with respect to certain automobile, fire, homeowner's, commercial, and mortgage guarantee insurance, as specified; establish the Commission on Insurance Redlining which would analyze and evaluate the extent to which insurance redlining exists, as specified; require the Commission to report its findings to the legislature, the Governor, local entities, and the public by March 1, 1995; make a $300,000 appropriation from the Insurance Fund to the Commission for these purposes; provide that the provision creating the Commission would remain in effect only until December 31, 1995; require the biennial submission of a disclosure report to the Insurance Commissioner providing certain information; require the issuance of certain reports and specify an evaluation system by the Commissioner; require the Commissioner to establish a schedule of fees to be paid by insurers to cover the actual administrative and operational costs, as specified, arising from the implementation and requirements of the provisions added by this act; and limit the costs of implementation of these provisions to $500,000. *[A. W&M]*

**SB 773 (Hart)**. Existing law provides that applicants for a child day care license shall attend an orientation conducted by the State Department of Social Services prior to licensure, as specified. As introduced March 3, this bill would require that orientation to disclose that insurers offering commercial and homeowners' insurance are required to offer liability insurance for family day care homes.

Existing law prohibits the arbitrary cancellation of a policy of homeowners' insurance solely on the basis that the policyholder is engaged in a licensed family day care business at the insured location. This bill would prohibit the arbitrary cancellation of a policy of homeowners' or commercial rental insurance solely on the basis that the policyholder or occupant, or both, are engaged in a licensed family day care business at the insured location. This bill would also require, on and after July 1, 1994, insurers that offer policies of homeowners' insurance and also offer commercial insurance to also make available liability coverage for licensed family day care homes. The bill would also provide that this provision shall not be construed to require an insurance company to make available liability insurance to a homeowner operating a licensed family day care home, if the homeowner is not a policyholder of that company. *[A. F&I]*

**SB 907 (Leonard)**, as amended June 9, would require every workers' compensation insurer, private self-insurer, and third-party administrator that administers self-insured employers workers' compensation claims, to certify, as specified, that a utilization review and quality assurance plan that conforms to minimum specified guidelines has been established and implemented. *[A. F&I]*

**AB 1667 (Hoge)**. Existing law establishes a California Insurance Guarantee Association and specifies those insurers which are required to be members of the Association; it exempts certain classes of insurance from assessments and other requirements of the Association. As amended May 12, this bill would specifically enumerate those exempt classes of insurance and provide that any insurer admitted to transact only those classes or kinds of insurance excluded from specified provisions shall not be a member of the Association. *[S. InsCl&Corps]*

**SB 1066 (Mello)**, as amended April 15, would prohibit the issuance of any life insurance policy or certificate, except credit life insurance, life insurance where the death benefit is $25,000 or more, and noncontributory group life insurance, unless the benefit payable at death equals or exceeds the cumulative premiums to be paid for the first ten years, plus interest thereon, as specified. It would provide for certain administrative penalties for any violation of that requirement. *[S. Appr]*

**AB 998 (Tucker)**. Existing law prohibits as an unfair method of competition and as an unfair and deceptive practice in the business of insurance the making of any misleading statement or representation as to specified terms of insurance policies. In addition, the Insurance Commissioner may disapprove the form of credit life and disability policies if they contain misleading provisions, and shall disapprove the forms of specified extended health insurance policies if the

Commissioner finds they are misleading. As introduced March 1, this bill would specifically authorize the Insurance Commissioner to examine policy forms and to prohibit the use of forms that are deceptive or misleading. *[S. InsCl&Corps]*

**AB 1782 (Tucker)**. Existing law prohibits certain discriminatory practices by admitted insurers, as specified. As amended July 8, this bill would create, in DOI, an Insurance Availability Study Commission for specified purposes. The bill would specify membership and require a report to be issued to the Governor, legislature, and Insurance Commissioner no later than October 1, 1995. The bill would appropriate $500,000 from the Insurance Fund for specified purposes. These provisions would be repealed on January 1, 1996. *[S. InsCl&Corps]*

**SB 286 (Presley)**, as amended August 19, is no longer relevant to the Department of Insurance.

## LITIGATION

On December 8, the Second District Court of Appeal handed a major victory to Proposition 103 supporters in ***Amwest Surety Insurance Company v. Wilson***, 20 Cal. App. 4th 1275, on the issue of the extent to which the legislature may amend the provisions of law added by Proposition 103, the insurance rate reform initiative passed by the voters in 1988. Section 8(b) of the initiative states that the legislature may amend it only to "further its purposes." In this matter, the Commissioner and Proposition 103 sponsor Voter Revolt contend that the legislature's passage of AB 3798 (Johnston) (Chapter 562, Statutes of 1990), which exempted surety companies from the rollback and prior approval provisions of Proposition 103, does not "further the purposes" of the initiative and is thus beyond the authority of the legislature. *[13:2&3 CRLR 130; 11:3 CRLR 133–34]*

In a 2–1 decision, the Second District found that the proposition expressly applies to "all insurance on risks or on operations in this state, except those listed in Section 1851." At the time Proposition 103 was enacted, Section 1851 exempted certain types insurance from the ratesetting provisions of the initiative, but not surety insurance. Thus, the court found that "[t]he plain meaning of Proposition 103 is that surety is subject to its requirements....The Legislature's 'finding' that AB 3798 'furthers the purpose of Proposition 103 by clarifying the applicability of the proposition to surety insurance,' fails to rationally justify the Legislature's action. It in effect declares that Proposition 103 was not *intended* to cover surety, despite its clear language to the contrary. On the other hand, if the Legislature concluded that Proposition 103 rate regulations *should not* apply to surety, then it is evident the amendment does not further the purposes of the initiative as adopted by the people. In either case, the conclusion is that AB 3798 is invalid" (emphasis original).

Significantly, the court noted that the legislature's "plenary" power is "subject to the exception of the powers of initiative and referendum which are reserved to the people" under article II, section 10(c) of the California Constitution. The court cited a long line of California Supreme Court cases which have "jealously guarded" the initiative process and the people's initiative power, and quoted *Amador Valley Joint Union High School District v. State Board of Equalization*, 22 Cal. 3d 208 (1978) for the rule that "the power of initiative must be liberally construed...to promote the democratic process" ("the initiative is in essence a legislative battering ram which may be used to tear through the exasperating tangle of the traditional legislative procedure and strike directly toward the desired end").

At this writing, the insurance industry is expected to petition the California Supreme Court for review of the *Amwest* decision. More than AB 3798 is at stake for the industry. Last year, insurers succeeded in convincing the legislature to pass and the Governor to sign three other bills which arguably fail to "further the purposes" of Proposition 103: AB 1086 (Campbell) (Chapter 1219, Statutes of 1993), which—despite Proposition 103's application of California antitrust law to insurers—permits insurers to circulate among themselves data collected by industry trade associations; SB 871 (Johnston) (Chapter 646, Statutes of 1993), which requires the Insurance Commissioner to act on rate change applications within 180 days or the changes are deemed approved; and SB 905 (Maddy) (Chapter 1248, Statutes of 1993), which allows insurance agents and brokers to keep the 15%–25% commissions they earned during the 1988–89 rollback year. *[13:4 CRLR 117]* Both Commissioner Garamendi and the Proposition 103 Enforcement Project are considering challenges to the three 1993 bills.

Another major Proposition 103 case is still pending before the California Supreme Court. The final brief in ***20th Century Insurance Company v. Garamendi***, No. S032502, was filed on August 25, but—at this writing—oral argument has yet to be scheduled. The *20th Century* case is a direct appeal from Los Angeles County Superior Court Judge Dzintra I. Janavs' February 1993 invalidation of the Commissioner's regulations implementing Proposition 103's rollback requirement. *[13:4 CRLR 122; 13:2&3 CRLR 139–40]*

## DEPARTMENT OF REAL ESTATE

*Commissioner: Clark E. Wallace*
*(916) 739-3684*

The Real Estate Commissioner is appointed by the Governor and is the chief officer of the Department of Real Estate (DRE). DRE was established pursuant to Business and Professions Code section 10000 *et seq.*; its regulations appear in Chapter 6, Title 10 of the California Code of Regulations (CCR). The commissioner's principal duties include determining administrative policy and enforcing the Real Estate Law in a manner which achieves maximum protection for purchasers of real property and those persons dealing with a real estate licensee. The commissioner is assisted by the Real Estate Advisory Commission, which is comprised of six brokers and four public members who serve at the commissioner's pleasure. The Real Estate Advisory Commission must conduct at least four public meetings each year. The commissioner receives additional advice from specialized committees in areas of education and research, mortgage lending, subdivisions and commercial and business brokerage. Various subcommittees also provide advisory input.

DRE primarily regulates two aspects of the real estate industry: licensees (as of September 1993, 255,158 salespersons and 115,974 brokers, including corporate officers) and subdivisions. Certified real estate appraisers are not regulated by DRE, but by the separate Office of Real Estate Appraisers within the Business, Transportation and Housing Agency.

License examinations require a fee of $25 per salesperson applicant and $50 per broker applicant. Exam passage rates averaged 56% for salespersons and 48% for brokers (including retakes) during the 1991–92 fiscal year. License fees for salespersons and brokers are $120 and $165, respectively. Original licensees are fingerprinted and license renewal is required every four years.

In sales, or leases exceeding one year in length, of any new residential subdivisions consisting of five or more lots or units, DRE protects the public by requiring that a prospective purchaser or tenant be given a copy of the "public report." The